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IN THE

Supreme Court of the United States

WHOLE WOMAN'S HEALTH, ET AL.,
Petitioners,

v.

JOHN HELLERSTEDT, COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF *AMICUS CURIAE* LEGAL CENTER FOR DEFENSE OF LIFE IN SUPPORT OF RESPONDENTS

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QUESTIONS PRESENTED

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, this Court reaffirmed that the decision to end a pregnancy prior to viability is a fundamental liberty protected by the Due Process Clause. 505 U.S. 833, 845-46 (1992). It held that a restriction on this liberty is impermissible if it amounts to an undue burden. *Id.* at 876-77. Under this standard, states may not enact "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion." *Id.* at 878.

The questions presented are:

(a) When applying this standard, does a court err by refusing to consider whether and to what extent laws that restrict abortion for the stated purpose of promoting health actually serve the government's interest in promoting health?

(b) Did the Fifth Circuit err in concluding that this standard permits Texas to enforce, in nearly all circumstances, laws that would cause a significant reduction in the availability of abortion services while failing to advance the State's interest in promoting health – or any other valid interest?

II

Did the Fifth Circuit err in holding that res judicata provides a basis for reversing the district court's judgment in part?

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INTERESTS OF *AMICUS CURIAE*[1]

Amicus Legal Center for Defense of Life ("LCDL") is a non-profit organization based in Morristown, New Jersey. Founded in 1989, LCDL defends the sanctity of life from the moment of conception. LCDL also provides pro bono services to women facing problem pregnancies. LCDL seeks to ensure that pregnant women are accurately and completely informed of their rights and of the medical and

[1] No counsel for a party authored this brief in whole or in part. No person or entity other than *Amicus*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief. *Amicus* files this brief with the written consent by all parties, as filed concurrently with this brief.

biological facts about their pregnancy and the humanity of the unborn child. LCDL is concerned that women who are considering or undergoing abortion receive the same standard of care as any patient undergoing any other surgical procedure. LCDL has, for example, arranged for representation of the estate of a woman who died as a result of negligence during an abortion procedure.

Amicus LCDL has a direct and vital interest in this case to defend the power of States to limit the exploitation of women by the abortion industry.

SUMMARY OF ARGUMENT

There is no constitutional right to a cheap, "back-alley" abortion. States can lawfully prohibit less safe abortions by requiring providers to be available at a nearby hospital to handle complications, and by requiring abortion clinics to comport with general surgical standards. Nothing in *Roe v. Wade* or its progeny give the abortion industry the right to increase risks to women and to shift costs of complications from its procedures onto the public. Favoritism for the abortion industry must not extend so far as to expand *Lochner v. New York* and its progeny for the benefit of abortion providers and to the detriment of women.

Complications from abortion are costly and sometimes life-threatening. They harm the substantial numbers of women who are injured by them. Worldwide, according to the pro-choice Guttmacher Institute, "8.5 million women experience complications [from abortion] that require medical

attention each year; 3 million do not receive care."[2] The Guttmacher Institute observes that "Complications from unsafe abortion procedures account for 13% of all maternal deaths, or 47,000 per year."[3] These are large numbers, and most of these injuries and deaths occur in developing countries. But some occur in the United States, and injuries and deaths from abortion may be increasing in some regions just as mortality from childbirth is increasing.

For any other medical procedure, it is a basic professional responsibility for the physician who caused a complication to remain available for efforts to repair it. A State may properly prohibit abortion clinics from shirking that cost and duty, by requiring nearby hospital admitting privileges before an abortion may be performed. The abortion industry has an economic incentive to externalize its costs by shifting them onto others, but a State has the power to limit such cost-shifting by an industry onto the public, as Texas has done in enacting its Act of July 12, 2013, 83d Leg., 2d C.S., ch. 1, 2013 Tex. Gen. Laws 5013 (HB 2).

For years we have heard the repeated mantra that abortion should be "*safe*, legal, and rare." Abortion is surgery, and life-changing surgery at that. Ideally it should be performed only in hospitals, but HB 2 does not even ensure that much. Instead, HB 2 merely requires that most abortions be done in an ambulatory surgery center (ASC) to attain the same

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[2] https://www.guttmacher.org/presentations/abort_slides.pdf (slide 49 out of 58, viewed Jan. 24, 2016).

[3] *Id.*

standard of care that is commonly provided for other procedures of similar complexity. This reform reduces the risk of costly complications that do sometimes occur, and it is well within the regulatory power of Texas to require a higher standard of care for a surgical procedure. Physicians perform more than 23 million procedures in ASCs annually nationwide,[4] and Texas may require that abortion be among those procedures.

Ultimately Petitioners pretend that the Texas regulations are somehow too expensive for them to comply with. But that is not a constitutional basis for overturning HB 2. Moreover, the abortion industry is highly profitable and has enormously wealthy supporters, and Petitioners cannot prevail on a hardship argument for a business that has no such hardship. Instead, the abortion industry simply wants to continue to shift costs onto the public, as factories and smokestack industries did until limited by government regulation. The Constitution does not prevent States from reducing cost-shifting by industries.

Economically, this case is indistinguishable from *Harris v. McRae*, where the abortion industry unsuccessfully demanded that taxpayers fund abortion. Here, the abortion industry demands a right to continue to shift costs and risks of complications from abortion onto the public, without abortion providers comporting with common standards of care prevalent in the medical profession.

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[4] http://www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/50-things-to-know-about-the-ambulatory-surgery-center-industry.html (viewed Jan. 17, 2016).

Just as this Court rejected the demand for an entitlement in *Harris v. McRae*, this Court should reject Petitioners' demands for special treatment here also.

ARGUMENT

I. Missouri Has Had a Similar Admitting-Privileges Requirement for a Decade, and It Has Worked Well to Protect Women.

The same hospital admitting privileges rule that is part of Texas HB 2 has worked well in Missouri for more than a decade, without abortion clinics challenging it before this Court:

> Any physician performing or inducing an abortion who does not have clinical privileges at a hospital which offers obstetrical or gynecological care located within thirty miles of the location at which the abortion is performed or induced shall be guilty of a class A misdemeanor, and, upon conviction shall be punished as provided by law.

§ 188.080 R.S.Mo. (2005).

This simple requirement helps ensure that there is a genuine physician-patient relationship for an abortion, such that the physician is available to provide follow-up care as is customary for the remainder of the medical profession. Neither *Roe v. Wade* nor its progeny support a separate abortion industry that operates with its own rules, abandoning patients who have complications by telling them to call "911" or show up at an unfamiliar Emergency

Room somewhere. 410 U.S. 113 (1973). The judicially created "right to an abortion" is not a right to an unsafe abortion, a cheap abortion, or an abortion procured regardless of the risk to health. There is no right for the abortion industry to shift its costs onto the public. The "right to an abortion" cannot mean anything more than the right to a procedure consistent with quality standards established by the State, to be performed by a physician acting in full compliance with the norms and ethics of the medical profession.

Hospitals typically require that physicians carry malpractice insurance as a condition of being on the medical staff, for the protection of patients who are injured by negligence. Bruce Japsen, "Doctors risk practicing without costly insurance; Some roll dice on huge lawsuit judgments rather than face certainty of huge malpractice bills," *Chicago Tribune* C1 (March 18, 2004) (observing that it is "a common requirement that doctors maintain malpractice coverage as a prerequisite for serving on staff" at a hospital). Abortion clinics, however, typically do not require the physician to carry any malpractice insurance. *See, e.g.*, Eyal Press, "A Botched Operation," *The New Yorker* (Feb. 3, 2014) (an abortion victim's attorney discovered that the physician lacked malpractice insurance, despite his sworn statement affirming otherwise).[5] Any woman who has had an abortion in Missouri in the past decade benefits from the protection of the foregoing Missouri law, while many women who have had an abortion in Texas have

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[5] http://www.newyorker.com/magazine/2014/02/03/a-botched-operation (viewed Feb. 2, 2016).

lacked that benefit. In no area of medicine other than abortion would an industry be entitled to operate with such disregard for its patients. It is well within the authority of the State of Texas to confer on its residents the same protections that women in Missouri have enjoyed.

The maternal mortality rate has increased significantly in the United States over the past quarter-century, despite decreasing in other developed nations over the same time period. "Death from childbirth is unusually common in America," but causes other than abortion are inadequate in explaining it. *See* "Exceptionally deadly," *The Economist* (July 18, 2015).[6] The decreasing safety for pregnant women in the United States has made it "international outlier":

> Between 2003 and 2013 [the United States] was one of only eight countries, including Afghanistan and South Sudan, to see its maternal-death rate move in the wrong direction. American women are now more than three times as likely to die from pregnancy-related complications as their counterparts in Britain, the Czech Republic, Germany or Japan.

Id. Mortality in childbirth is due to complications, and many of those complications are caused by prior abortions. *See, e.g.*, Marianne S. Hendricks, Y. H. Chow, B. Bhagavath and Dr. Kuldip Singh, "Previous Cesarean Section and Abortion as Risk Factors for

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[6] http://www.economist.com/news/united-states/21657819-death-childbirth-unusually-common-america-exceptionally-deadly (viewed Jan. 24, 2016).

Developing Placenta Previa," 25 *Journal of Obstetrics and Gynaecology Research* 137 (April 1999).[7]

The Guttmacher Institute estimates that there is a complication rate of up to 0.5% from abortion, and that in Texas there were 73,200 abortions in 2011.[8] Even at this low estimate for a complication rate, this demonstrates that there are still hundreds of complications from abortion each year in Texas, many of which require hospitalization and some of which end in death. This imposes millions of dollars in costs, and substantial issues of safety for the injured women. Texas may properly enact HB 2 to improve the quality of care and reduce the shifting of costs onto the public by the abortion industry.

It is no argument against HB 2 to insist that other physicians are not required to have hospital admitting privileges, because most physicians do as a matter of professional responsibility. *See, e.g.*, Clinton C, Schmittling G, Stern TL, Black RR, "Hospital privileges for family physicians: a national study of office based members of the American Academy of Family physicians," 13 *J. Fam. Pract.* 361 (Sept. 1981) ("The vast majority of family physician/general practitioners in direct patient care in an office based setting have hospital admission privileges in one or more hospitals.").[9] This suffices to explain why the hospital admitting privileges

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[7] http://onlinelibrary.wiley.com/doi/10.1111/j.1447-0756.1999.tb01136.x/abstract (viewed Feb. 2, 2016).

[8] https://www.guttmacher.org/pubs/sfaa/texas.html (viewed Jan. 24, 2016).

[9] http://www.ncbi.nlm.nih.gov/pubmed/7276846 (viewed Feb. 2, 2016).

requirement may not be demanded of non-abortion ASC practitioners. In fact, it is rather remarkable that the abortion-doctor plaintiffs are complaining that they are required to have hospital admission privileges. What ordinary obstetrician-gynecologist would not have admitting privileges in a hospital to handle complications from his own procedures?

Yet the abortion industry seeks *sui generis* status, using a business model that is not consistent with any other area of the medical profession. It is common, for example, for abortion clinics to fly in an abortionist from another State to perform numerous abortions locally and then leave town. *See, e.g.*, John H. Richardson, "The Abortion Ministry of Dr. Willie Parker," *Esquire* 152 (Sept. 1, 2014) (describing how the abortionist "rushes around all the time, flying from Chicago to Philadelphia to Birmingham"). No other aspect of the medical profession practices in such a "hit and run" manner. It is within the power of the State to limit exploitive practices that have developed in one particular part of the medical profession, without applying the same requirement across-the-board to other specialists who do not violate the requirement anyway.

Nor must Texas accept mere transfer agreements between abortion clinics and hospitals as being adequate to protect the interests of the State. *See Whole Woman's Health v. Cole*, 790 F.3d 563, 579 n.19 (5th Cir.) (observing that miscommunication and misdiagnosis can occur when a patient is transferred between health care providers), *cert. granted*, 136 S. Ct. 499 (2015). A transfer agreement does not ensure the availability of the physician, who caused the

complication, to assist in providing follow-up care to address the complication. Moreover, a transfer agreement does not protect the woman by ensuring that a physician will have adequate malpractice insurance for mistakes that occurred during the abortion procedure.

In economic terms this case is indistinguishable from *Harris v. McRae*, where this Court rejected a constitutional right to public subsidies for abortion:

> [T]he Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom. To hold otherwise would mark a drastic change in our understanding of the Constitution.

448 U.S. 297, 317-18 (1980). Here, the abortion industry seeks a constitutional right to cut corners in its business, performing operations without customary medical staff privileges and without conforming to ASC standards. Cutting corners results in inevitable costs, which the abortion industry seeks to continue to shift onto the public, as in the costs of complications. But there is no constitutional right for any business to shift costs onto the public, just as there is no right to taxpayer funding for abortion, as established by *Harris v. McRae*.

The decision by the Fifth Circuit below should be affirmed with respect to hospital admitting privileges.

II. ASCs Are Safer than Offices for Surgery, and a State May Require Safety in Connection with Abortion.

Ambulatory Surgery Centers (ASCs) are increasingly the standard of care for relatively simple procedures, such as colonoscopies, cataract removal, spinal injections, and joint repairs. *See* Sandra G. Boodman, "Are surgery centers safe?", *The Washington Post* E01 (Dec. 16, 2014). The overall rate of complications for procedures done at ASCs is only 0.1%, which is significantly lower than the estimated rate of up to 0.5% for complications from abortion at clinics. *Id.*

More than two-thirds of all operations are performed now in ASCs, which make ASCs the standard of care today:

> The number of ambulatory surgery centers or ASCs which perform procedures such as colonoscopies, cataract removal, joint repairs and spinal injections on patients who don't require an overnight stay in a hospital has increased dramatically in the past decade, for reasons both clinical and financial. More than two-thirds of operations performed in the United States now occur in outpatient centers, some of which are owned by hospitals. The number of centers that qualify for Medicare reimbursement increased by 41 percent between 2003 and 2011, from 3,779 to 5,344, according to federal statistics. In 2006 nearly 15 million procedures were performed in surgery centers; by 2011 the number had risen to 23 million.

Id.

The Guttmacher Institute emphasizes that the less safe an abortion is, the higher the complication rate will be. The relatively high rate of 0.5% from abortion can be reduced to the 0.1% complication rate at ASCs by requiring that most abortions be performed in ASCs. This is what HB 2 does, and it thereby improves safety for women. Surely it is constitutional for a State to take steps to lower the risk of medical harm to patients, particularly since the abortion industry does not regulate itself to the same degree that other surgical professionals do.

ASCs attain greater safety and lower complication rates, albeit it at a greater cost for the providers. But the providers should be bearing such costs, and HB 2 may properly require them to do so. This type of regulation is no different from requiring greater safety for hospitals, automobiles, restaurants, airplanes, elevators, factories, and every other commercial activity in life. There is no constitutional right of a business to operate in a lower-cost, higher-risk manner. To overturn HB 2 would perpetuate the errors of *Lochner v. New York* and deny the legitimate authority of the State to protect the safety of its inhabitants in the commercial activity of abortion. 198 U.S. 45 (1905).

Opponents of HB 2 have euphemistically compared the abortion procedure to a colonoscopy. But colonoscopies are routinely done in ASCs now.[10] One could hardly doubt that a State may require that colonoscopies be done in hospitals or ASCs without

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[10] http://www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/50-things-to-know-about-the-ambulatory-surgery-center-industry.html (viewed Jan. 24, 2016).

transgressing the Constitution. Abortionists simply should not be entitled to operate in a manner outside the parameters of the medical profession.

Even accepting the abortion industry's argument regarding economic feasibility, the costs for the abortion industry to comply with ASC standards pales in comparison to the costs of hospitalizations from abortion complications, and government may properly seek to reduce that cost-shifting. *See NFIB v. Sebelius*, 132 S. Ct. 2566, 2611 (2012) (Ginsburg, Breyer, Sotomayor, Kagan, JJ., concurring) (upholding the constitutionality of the Patient Protection and Affordable Care Act because it reduces "cost-shifting" in connection with health insurance).

The decision by the Fifth Circuit below should be affirmed with respect to the ASC requirement.

CONCLUSION

For the foregoing reasons, the decision below by the court of appeals should be affirmed.

Respectfully submitted,

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